MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH CARE NEEDS

ADULT HEAD INJURY PROGRAM PRIOR AUTHORIZATION MODIFICATION

CLIENT NAME (LAST, FIRST, MI)	DCN
PROVIDER NAME	
PROVIDER ADDRESS	CONTACT PERSON

ADULT HEAD INJURY PROGRAM PRIOR AUTHORIZATION (PA) MODIFICATION FORM

- A modification form must be completed for each service modified for the participant.
- If a new service or new provider will replace a discontinued service, a new PA must be submitted by the provider in addition to the modification form.

Cognitive/Behavioral
- ☐ 0005 - Neuropsychological Evaluation/Consultation
- ☐ 0006 - Behavioral Assessment and Consultation

Adjustment Counseling - Individual
- ☐ 0010 - Psychologist
- ☐ 0011 - Social Work
- ☐ 0012 - LPC

Adjustment Counseling - Group
- ☐ 0013 - Psychologist
- ☐ 0014 - Social Work
- ☐ 0015 - LPC

Community Intergration
- ☐ 0004 – Transitional Home and Community Support
- ☐ 0138 - Socializations Skills Training (3 hr half day)

Educational/Vocational
- ☐ 108 - Pre-Voc/Pre-Emp Training (3 hr half day)
- ☐ 0008 - Pre-Voc/Pre-Emp Training (6 hr half day)
- ☐ 0009 - Supported Employment-Long Term Follow-Up
- ☐ 0007 - Special Instruction

Transportation
- ☐ 0026 - Individual
- ☐ 0027 - Group Same Location
- ☐ 0028 - Group

COMMENTS: PROVIDER MUST JUSTIFY REASON FOR THE INCREASE OR DECREASE IN THE COMMENTS SECTION.

MONTH / YEAR	ORIGINAL AUTHORIZED UNITS	REQUESTED MODIFIED UNITS

SERVICE COORDINATOR ONLY		PROGRAM MANAGER ONLY	
DATE RECEIVED		☐ APPROVED ☐ DENIED	DATES OF APPROVAL TO
RECOMMENDATION ☐ APPROVED ☐ DENIED ☐ MODIFY		COMMENTS	
SERVICE COORINATOR'S SIGNATURE		PROGRAM MANAGER'S SIGNAUTURE	
UPON COMPLETION - INITIAL AND DATE	MOHSAIC ENTRY	SENT TO PROVIDER	SENT TO S.C.